



**Request for Paid Leave  
Medical Maternity & Parental Leave**

Employees are expected to give at least one week's notice of the need for leave whenever possible. If emergency circumstances prevent the employee from giving one week's notice, the employee is expected to give as much notice as possible. Family Medical Leave (FMLA) will run concurrently with the leaves of absence listed on this form. Completed forms need to be sent to [employeebenefits@byuh.edu](mailto:employeebenefits@byuh.edu)

Employee Information		
Name of Employee (last, first, middle)		Employee ID #
Department		Date
Estimate date is leave to begin	Estimated date of return	Original date of hire
Reason for Leave		
Medical Maternity Leave- 6 calendar weeks		
Parental Leave- 5 consecutive work days		Birth date or Adoption date
Benefits participation during leave		
All insurance premiums and other standard deductions will continue to be deducted from employee's pre-tax earnings.		
I acknowledge that I have notified my supervisor and the Human Resource (HR) Department representative of my leave of absence for the reason noted above. I understand that no work is to be performed during this period. If changes occur that affect my leave. I understand that it is my responsibility to notify my supervisor and the HR department of those changes.		
Employee signature		Date
Supervisor signature		Date
HR representative signature		
Office Use Only		
FMLA Eligible <input type="checkbox"/> Yes <input type="checkbox"/> No	FMLA hours available	Initials of reviewer
Eligible for other state or local programs		